

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3734 CERTIFICATE OF DEATH 03729											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 DAY 11 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVENUES</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>ROUTE #3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DONALD</b>			First <b>CARL</b>			Middle <b>BENNETT</b>			Last <b>APRIL</b>		
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>APRIL 18, 1961</b>		
9. AGE (In years last birthday) yrs. <b>1</b>			IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b>			IF UNDER 24 HRS. Hours <b>11</b> Min. <b>11</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>ROBERT C. BENNETT</b>						14. MOTHER'S MAIDEN NAME <b>BERNICE KEESEE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes, give number and date of service)			17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5 Hyaline Membrane Disease</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) <b>Prematurity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at <b>9:00AM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>Robert D. Brodell</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>						22d. ADDRESS <b>129 S. LIBERTY ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-21-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cohasset Mines Md</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. P. Durant</b> ADDRESS <b>Frostburg Md.</b>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		
DATE <b>APR 24 '61</b>											

2060201XV3

(M)

(I)

ALLGAIN

CINGERLAND

MEMORIAL HOSPITAL

MEMORIAL & WASHINGTON AVENUES

BOWERS

CARL

BENNETT

APRIL

19

MALE

WHITE

APRIL 15, 1901

1

CINGERLAND, MD.

U.S.A.

DERMIS KESSEL

ROBERT C. BENNETT

MEMORIAL HOSPITAL - CINGERLAND, MD.

MODERN

DR. ROBERT A. BRODIE

152 S. LIBERTY ST., CINGERLAND, MD.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3735

## CERTIFICATE OF DEATH

03730

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>51 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b> d. STREET ADDRESS <b>Newtown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>BENNETT</b> Last <b>BENNETT</b>			<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>15</b> Year <b>1961</b>				
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>MARCH 2, 1884</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Yard Master</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>C &amp; P Railroad</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>JOHN BENNETT</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>MAZIE PERDEW</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>712-14-1541</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis - Uremia</b> 422.1 DUE TO (b) <b>Myocardial Degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Atherosclerosis &amp; senility</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Cumberland Allegany</b> <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4/18/61</b> , 19____, to <b>4/15/61</b> , 19____, that (X) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>RICHARD J. WILLIAMS</b> M.D. <b>22b. DATE SIGNED</b> <b>4/17/61</b> <b>22d. ADDRESS</b> <b>122 SOUTH CENTRE ST., CUMBERLAND, MD.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/18/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Savage Meth. Cem.</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Mt. Savage, Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Wayne George, Cumberland, Md.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 19 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

03430

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ALLEGEDLY

CONSPIRACY

MEMORIAL HOSPITAL  
MEMORIAL & WILMINGTON AVES.

WILLIAM

MALE WHITE

RESIDENT 1200 W. 12TH ST. ST. LOUIS, MO.

JOHN BENNETT

MARYLAND

31 DAYS OF MARYLAND

1200 W. 12TH ST.

BENNETT

MARCH 2, 1930

MARYLAND

WHITE PERSON

12

APRIL 17

U.S.A.

MEMORIAL HOSPITAL - CUMBERLAND, MD.

RICHARD J. WILLIAMS

125 SOUTH CENTRE ST., CUMBERLAND, MD.

125 SOUTH CENTRE ST., CUMBERLAND, MD.

125 SOUTH CENTRE ST., CUMBERLAND, MD.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03731

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN lb <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>MAYNARD</u> Last <u>BISHOP</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>19 61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRED BISHOP</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE LUDWIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>J. O. BISHOP</u>		Address <u>CRESAPTOWN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>RETROPERITONEAL HEMORRHAGE, FRACTURED PELVIS,</u> (c) <u>FRACTURE OF TIBIA AND FIBULA, RIGHT; FRACTURE OF RIGHT HUMERUS; CONTUSION OF BRAIN.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 Hours.</u> <u>7 Hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STRUCK BY AUTO----Pedestrian</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:00</u> <u>P. M.</u> <u>April 14</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 220 Fairgo, Rt. 5 Cumberland, Alleg. Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>APRIL 15, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 18, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FROSTBURG MEMORIAL PARK</u>	22d. LOCATION (City, town, or county) (State) <u>FROSTBURG, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>		24a. REC'D BY REGISTRAR <u>DATE APR 18 '61</u>	
ADDRESS <u>CUMBERLAND, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

LABYRINTH STATE DEPARTMENT OF MINING-BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03732  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 hrs. 53 Min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>539 B. Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>D</b> Last <b>BOCH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/34</b>
9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wesley O. Kenney</b>		14. MOTHER'S MAIDEN NAME <b>Daisy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Francis Boch La Vale MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acidosis, Coma</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Ashby W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumber MD</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>APR 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00382

NAME OF DECEASED <b>JOHN B. BROWN</b>		AGE <b>45</b>		SEX <b>Male</b>		RACE <b>White</b>		DATE OF DEATH <b>April 10, 1961</b>	
PLACE OF DEATH <b>Home</b>		CITY <b>Baltimore</b>		COUNTY <b>Harford</b>		STATE <b>Maryland</b>		ZIP CODE <b>21040</b>	
OCCUPATION <b>None</b>		EDUCATION <b>High School</b>		RELIGION <b>None</b>		MARRIAGE <b>Married</b>		SPOUSE'S NAME <b>None</b>	
CAUSE OF DEATH <b>Heart Disease</b>		MANNER OF DEATH <b>Natural</b>		IMMEDIATE CAUSE <b>Myocardial Infarction</b>		UNDERLYING CAUSE <b>Coronary Artery Disease</b>		OTHER CAUSES <b>None</b>	
SIGNS AND SYMPTOMS <b>None</b>		HISTORY <b>None</b>		PHYSICAL EXAMINATION <b>None</b>		LABORATORY EXAMINATIONS <b>None</b>		X-RAY EXAMINATIONS <b>None</b>	
PATHOLOGICAL FINDINGS <b>None</b>		TOXICOLOGICAL FINDINGS <b>None</b>		ANTHROPOLOGICAL FINDINGS <b>None</b>		FORENSIC FINDINGS <b>None</b>		OTHER FINDINGS <b>None</b>	
SIGNATURE OF EXAMINER <b>John B. Brown</b>		DATE <b>April 10, 1961</b>		PLACE <b>Baltimore</b>		COUNTY <b>Harford</b>		STATE <b>Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3738

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03733

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>Midland</u>	
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Susan</u> Last <u>Boggs</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Sutton Braxton Co. W.Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel M. James</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Skidmore</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Clarence McCloud</u> Address <u>Midland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Fibillation + Myocardial failure</u> 260X DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Arteriosclerotic CV disease class IV</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 7, 1961</u> to <u>April 13, 1961</u> that (I) (we) last saw the deceased alive on <u>April 13, 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L.R. Miles, Jr. M.D.</u>		22b. DATE SIGNED <u>4.13.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR., M.D.</u>		22d. ADDRESS <u>LONA CONING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lost Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lost Creek, W.Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		25a. REC'D BY REGISTRAR <u>APR 14 '61</u>	
ADDRESS <u>Lonaconing, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	



0333

2388



*[Faint, mostly illegible text, possibly a form or document with multiple lines of writing.]*



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
3739 CERTIFICATE OF DEATH 03234										
1. PLACE OF DEATH a. COUNTY <b>M</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE # 1 RIDGELEY</b>					
c. LENGTH OF STAY IN 1b <b>1 DAY</b>					d. STREET ADDRESS <b>85X-3</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <b>MARYK</b> Middle <b>L.</b> Last <b>BORROR</b>		4. DATE OF DEATH		Month <b>APRIL</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 18-1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Ridgeley</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>PATRICK DAYTON</b>					14. MOTHER'S MAIDEN NAME <b>AMANDA LARGENT</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct - Pulmonary Edema</b> 420 <b>DO</b> DUE TO (b) <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1961</b> , to <b>April 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1961</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>DR. WYLAND DOERNER</b>					22b. DATE SIGNED <b>4-3-61</b>		22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Headsville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Headsville, W. Va</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>					ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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WEST VIRGINIA

ALLEGANY

ROUTE 1 RIDGELY

1 DAY

QUINCY

WATSON & L. CO. INC.  
AVES.

MEMORIAL HOSPITAL

301

APRIL

BORER

L.

WATSON

JANUARY 18-1900

FEMALE WHITE

WEST VIRGINIA FIRELEY U. S. A.

OVER

HOWARD

APPROX. EAGENT

PATRICK DAYTON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

None



DR. WYLAND BOENEN

4-3-81

Headsville Cemetery

Headsville, W. Va.

James F. Scatterall, C. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3740

Reg. Dist. No. 03735

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 WESTERNPORT			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 1 SIMMONS APARTMENT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL D. BRADLEY				4. DATE OF DEATH Month Day Year APRIL 6 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 14, 1896	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Cutter		10b. KIND OF BUSINESS OR INDUSTRY W. Va. Pulp Mill		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD BRADLEY				14. MOTHER'S MAIDEN NAME ANNA LINKSWALDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-07-5989		17. INFORMANT MEMORIAL & WARWICK AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 903.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SECONDARY TO RIGHT HIP FRACTURE, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF RIGHT HIP						INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS 4 DAYS	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Turned on ankle and fell					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9. p. m. 4/1 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern		20f. (City or town) (County) (State) Westernport-Allegany-Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <del>                    </del> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> APRIL 6, 1961			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/61		22c. NAME OF CEMETERY OR CREMATORY Bloomington		22d. LOCATION (City, town, or county) (State) Bloomington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>El. Bual-Westernport, Md.</i>				24a. REC'D BY REGISTRAR DATE APR 10 '61		24b. REGISTRAR'S SIGNATURE <i>Christina S. Trama</i>	

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
3741																			
CERTIFICATE OF DEATH																			
03736																			
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>13 HOURS</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>3 MARTIN ST.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>FRANCES</b> Last <b>BREWER</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> Year <b>19 61</b>														
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 20, 1898</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>ARTHUR T. COOK (DECEASED)</b>					14. MOTHER'S MAIDEN NAME <b>MAHALIA ( Unknown )</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Edward L. Brewer</b>					Address <b>116 N. Smallwood St. Cumb. Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis on</b> <b>420.1</b> DUE TO <b>an arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Base</b> DUE TO (c) <b>years</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 61</b> to <b>April 23 19 61</b> that (I) (we) last saw the deceased alive on <b>April 22 19 61</b> and that death occurred at <b>304</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>B. M. Schindler</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>4/25/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>BLANE M. SCHINDLER, M.D.</b>					22d. ADDRESS <b>43 GREENE ST, CUMBERLAND, MD.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>4/25/61</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Dawson Cemetery</b>					23d. LOCATION (City, town, or county) (State) <b>Dawson, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>					ADDRESS <b>Cumberland, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>APR 27 '61</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>				

03130

CERTIFICATE OF DEATH

3781

DECEASED

WEST VIRGINIA

ALLIANCE

REGISTERED

12 MONTH

12 MONTH

2nd WEST VIRGINIA

2nd WEST VIRGINIA

10 - 11

12 - 13

14 - 15

16 - 17

18 - 19

5 - 12, 1912

5 - 12, 1912

5 - 12, 1912

10 - 11

12 - 13

14 - 15

16 - 17

18 - 19 (Unknown)

18 - 19 (Unknown)

Charles H. Brown, Jr., 1000 Oakwood St., Park, Md.

1000

1000

*Handwritten signature*

*Handwritten signature*

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1000 - 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3742 CERTIFICATE OF DEATH 03737											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>26 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>13 GRAND AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>GEORGE L. BROWN</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>1961</b>								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 24, 1885</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Brakeman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			11. BIRTHPLACE (County & State, or foreign country) <b>OHIO-MARTINS FERRY</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JAMES M. BROWN</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH RINKER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>705-07-9741</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>			Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Unresected Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 days</b> (c) <b>4 months</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1961</b> to <b>April 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 18, 1961</b> , and that death occurred <b>10:40 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT</b>					22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr. 21, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>APR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		

03737

2243

ALLEGANY

MARYLAND

CUMBERLAND

25 DAYS

CUMBERLAND

13 ORATIO AVE

MEMORIAL HOSPITAL  
111 ORATIO AVE.

18 18 18

APRIL

BROWN

GEORGE

SEPT. 21, 1884

WHITE

OHIO - ELIZABETH STURDY

RAILROAD

ELIZABETH STURDY

JAMES W. BROWN

CUMBERLAND, MD.

MEMORIAL HOSPITAL

707-07-07

no

30 VIRGINIA AVE., CUMBERLAND, MD.

CLAY E. DUBRETT

CLAY E. DUBRETT

APR. 21, 1901

BURIAL

JAMES F. SCANTPELL, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3743

Item 9 Film G284

## CERTIFICATE OF DEATH

03738

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>	
c. LENGTH OF STAY IN TB <b>7 DAYS</b>		d. STREET ADDRESS <b>920 BEDFORD STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOWARD M. BURNS</b>		4. DATE OF DEATH Month Day Year <b>APRIL 7 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-1880</b>
9. AGE (In years last birthday) <b>80 8 1/2 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JACOB BURNS</b>		14. MOTHER'S MAIDEN NAME <b>MARY GAVER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 05 9345</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OBSTRUCTION OF THE COLON</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CARCINOMA OF THE COLON</b> (e), stating the underlying cause last. (c) <b>(Signed)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>unknown (2 years?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8:50 P.M.</b> 1959 to April 7, 1961, that (I) (we) last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>8:50 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>S. G. Weisman</b>		22b. DATE SIGNED <b>4/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>		22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 10, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

00733

ALLEGANY

WARRICK

CINCINNATI

3 DAYS

MEMORIAL & WARRICK AVES.

MEMORIAL HOSPITAL

350 BROAD STREET

APRIL

BURNS

WARRICK

04-01

12-01-1900

WHITE

WIFE

WARRICK

JACOB BURNS

WIFE COVER

MEMORIAL HOS. (TAL - CINCINNATI, MO.)

DR. S. O. WEISMAN

30 CLEVELAND ST., CINCINNATI, MO.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03739

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>GRANT</b> <b>Hardy</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIGGS, W. VA.</b> d. STREET ADDRESS <b>85X-3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CARL</b> First <b>G</b> Middle <b>CAIN</b> Last		4. DATE OF DEATH <b>APRIL</b> <b>16</b> Year <b>61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-39</b>
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BROWN O. CAIN</b>		14. MOTHER'S MAIDEN NAME <b>DOROTHY SWICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Brown Cain</b>		Address <b>Rig, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TETANUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PUNCTURE WOUND OF HEAL FROM TACK IN SHOE</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Puncture wound of heal from nail in shoe</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>about</b> <b>March 27 1961</b> P. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Riggs, Grant, W. Va.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 16, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 18, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cain Family</b>		22d. LOCATION (City, town, or county) (State) <b>Rig, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Arnold</b>		ADDRESS <b>Petersburg, W. Va.</b>	
24a. REC'D BY REGISTRAR <b>APR 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Arnold</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)  
15M 9/59

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3745

CERTIFICATE OF DEATH

03740

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 1, Frostburg,</b>		c. LENGTH OF STAY IN 1b <b>55 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mayme</b> Middle <b>Chapman</b> Last <b>Chapman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4th</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7th, 1892</b>
9. AGE (In years lost birthday) <b>68</b> rs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Munsie</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>N. Water St. Mrs. Clarence Powers, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with coronary insufficiency.</b> DUE TO (c) <b>4-5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arthritis of spine.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-1</b> 19 <b>61</b> , to <b>4-4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-4</b> 19 <b>61</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. C. Diehl,</b>		22b. DATE SIGNED <b>4/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. C. Diehl,</b>		22d. ADDRESS <b>39 W. Main St., Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg,</b>		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Hurst</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

0352

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3746

03741

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MERRICK, LONG ISLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, write place of death) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>31 ALICE AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>CHRISTOPHER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>4</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-8-1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hrs. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>SIDNEY KOERNER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN G. BLUE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiac Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1954</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>April 4 1961</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. G. O. Himmelwright</b>		22b. DATE SIGNED <b>4/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 7, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
ADDRESS <b>Cumberland Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

03711

03711



NEW YORK

ALLEGANY

MERRICK, LONG ISLAND

3 DAYS

CUMBERLAND

2000 & WARRICK AVES.

MEMORIAL HOSPITAL

31 ALICE AVENUE

CHETSTON

MARY

10-2-1887

WHITE

WEST VIRGINIA

AT HOME

FORGOTTEN

SUSAN D. BLUE

ELIZABETH KEEPER

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*Handwritten notes:*  
Cumberland Hospital - Greenbelt  
Cumberland Hospital - Greenbelt

*Handwritten:* 10-2-1887

*Handwritten:* 10-2-1887

X

*Handwritten signature:* Elizabeth K.

103 VIRGINIA AVE., CUMBERLAND, MD.

DR. D. D. HIGHT

CUMBERLAND HOSPITAL

2000 & WARRICK AVES.

ALLEGANY

10-2-1887

MEMORIAL HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3747  
CERTIFICATE OF DEATH  
03742

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>PENNSYLVANIA</b> c. COUNTY <b>BEDFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>75X-3</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>REUBEN K. CLAPPER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 8, 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 14, 1976</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Yellowcreek, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Elapper</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Kegariee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. R.K. Clapper, Hyndman, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Failure - uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Renal Failure</b> DUE TO (c) <b>Cancer of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx. 2 days</b> <b>approx. 6 mo.</b> <b>1950</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>approx. 1950</b> to <b>Apr. 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Topper</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John A. Topper</b>		22d. ADDRESS <b>Hyndman, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

03238

CERTIFICATE OF DEATH

03238

ATTACHED

CUNNINGHAM

3 DAYS

WINTER

APRIL 8, 1901

EDWARD E. CHAPMAN

AUG. 11, 1876

WHITE

USA

Yellowwood, Pa.

Postal Worker

Samuel Chapman

Nancy Chapman

Mrs. E. E. Chapman, Yellowwood, Pa.

Home

Yellowwood, Pa.

Edwards Cemetery

April 8, 1901

Yellowwood, Pa.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3748 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03743

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>44 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. A. Sacred Heart Hospital</u>				d. STREET ADDRESS <u>711 Arundel St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Walter</u> Middle <u>C.</u> Last <u>Clark</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>29</u> Year <u>19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1901</u>		9. AGE (in years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Mpnths Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Train Dispatcher Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sir John's Run, Md.</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John William Clark</u>						14. MOTHER'S MAIDEN NAME <u>Susan Spring</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>705-09-5208</u>		17. INFORMANT Address <u>Mrs. Walter C. Clark, Cumberland, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS, LEFT</u> DUE TO (c) <u>ALSO MYOCARDIAL INFARCTION, LEFT; OLD</u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>****</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>						DATE SIGNED <u>APRIL 29, 1961</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 2, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08743

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 2748 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 45		RACE White	
DATE OF DEATH May 10, 1943		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural		MEDICAL HISTORY None	
OCCASION OF DEATH Routine Examination		PRESENT ILLNESS None	
PHYSICIAN J. H. Harris		SIGNATURE OF EXAMINER J. H. Harris	
ADDRESS 1234 Main St.		CITY Baltimore	
STATE Md.		COUNTY Baltimore	
ZIP CODE 21201		TELEPHONE 1234	
EMPLOYER None		OCCUPATION None	
MARITAL STATUS Single		EDUCATION High School	
RELIGION Protestant		POLITICAL PARTY None	
SOCIAL SECURITY NUMBER None		MEDICAL INSURANCE None	
SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
DATE OF SIGNATURE May 10, 1943		PLACE OF SIGNATURE Baltimore, Md.	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03744

3749

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY in 1b <b>Lifetime</b>		d. STREET ADDRESS <b>93 Broadway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE SIMONS CLOSE</b>		4. DATE OF DEATH Month Day Year <b>4 14 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-1881</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William R. Simons</b>	
14. MOTHER'S MAIDEN NAME <b>Kathryn Williamson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Alex G. Close, 93 Broadway, Frostburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive Coronary Artery Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertensive Heart Disease</b> DUE TO (c) <b>20 yrs?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>4 14 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>	20f. (City or town) (County) (State) <b>Frostburg, Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 19 <b>61</b> to <b>4/14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , 19 <b>61</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rottstein M.D.</b>		22b. DATE SIGNED <b>4/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTTSTEIN M.D.</b>		22d. ADDRESS <b>48 Broadway - Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-16-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>	23d. LOCATION (City, town or county) (State) <b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montecant</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03745**

3750

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Williams Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>J.</b> Last <b>Conley</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1894</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b>	IF UNDER 24 HRS. Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert L. Conley</b>				14. MOTHER'S MAIDEN NAME <b>Florence V. Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 214-12-3159</b>		17. INFORMANT Address <b>James W. Conley 731 Oldtown Rd. Cumb. Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitaralic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitaralic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 27, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/1/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Mem. Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneal</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be released by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>3751</div> <div>03746</div> </div> </div> <div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> </div> </div> <div> <div> <div> <div>3. NAME OF DECEASED</div> <div>(Type or print)</div> </div> <div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> </div> </div> <div> <div> <div>5. SEX</div> <div>6. COLOR OR RACE</div> </div> <div> <div>7. MARRIED</div> <div>NEVER MARRIED</div> </div> </div> <div> <div> <div>8. DATE OF BIRTH</div> <div>9. AGE (In years last birthday)</div> </div> <div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> </div> </div> <div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> </div> </div> </div> <div> <div> <div>13. FATHER'S NAME</div> <div>14. MOTHER'S MAIDEN NAME</div> </div> </div> <div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>16. SOCIAL SECURITY NO.</div> </div> <div> <div>17. INFORMANT</div> <div>Address</div> </div> </div> <div> <div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div> </div> <div> <div> <div>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div> </div> <div> <div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> </div> <div> <div>20d. INJURY OCCURRED</div> <div>While at work</div> </div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> </div> </div> <div> <div> <div>21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred 8:30 AM from the causes and on the date stated above.</div> </div> </div> <div> <div> <div>22a. SIGNATURE</div> <div>22b. DATE SIGNED</div> </div> </div> <div> <div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>22d. ADDRESS</div> </div> </div> <div> <div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>23b. DATE THEREOF</div> </div> <div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>23d. LOCATION (City, town or county)</div> </div> </div> <div> <div> <div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>ADDRESS</div> </div> <div> <div>25a. REC'D BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> </div> </div> </div>											
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3752

CERTIFICATE OF DEATH

03747

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Little Orleans</b>				d. STREET ADDRESS <b>Little Orleans</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Willie Crawford</b>				4. DATE OF DEATH Month Day Year <b>4 30 19 61</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/29/1868</b>	
9. AGE (In years lost birthday) yrs. <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>George Crawford</b>				14. MOTHER'S MAIDEN NAME <b>Mahalia Morris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs Josephine Crawford, Little Orleans</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASHD</b> <b>420.0</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>10 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1959</b> to <b>Jan 8 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 8 1961</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank B Thomas III M.D.</b>				22b. DATE SIGNED <b>5-1-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frank B Thomas III M.D.</b>				22d. ADDRESS <b>Hancock, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/3/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Piney Plains Methodist</b>				23d. LOCATION (City, town, or county) (State) <b>Little Orleans, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Elmore</b>				25a. REC'D BY REGISTRAR <b>May 5 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur J. House</b>							

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS

(M)

(I)

I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas, and that the same is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1901.

Clerk of the County of Dallas, State of Texas.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3753

03748

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Althea</b> Middle <b>M.</b> Last <b>Craze</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8th</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18th, 1899</b>		9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT Address <b>Stanley Craze, 248 E. Main St. F'bg. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis</b> DUE TO <b>15 yrs.</b> (c) <b>Generalized Toxemia (g.v.)</b> DUE TO <b>3d</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, L.L.L.; Hypertensive-C.V. disease - acute failure, on admission</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
20e. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>3/29</b> 19 <b>61</b> , to <b>4/7</b> 19 <b>61</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>4/7</b> 19 <b>61</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank T. Harrat</b>				22b. DATE SIGNED <b>4/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>F. T. Harrat</b>	
22d. ADDRESS <b>26 W. Mechanic St., Frostburg, Md.</b>				22e. REC'D BY REGISTRAR <b>APR 11 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Harris</b>				24a. ADDRESS <b>Frostburg, Md.</b>		24b. REC'D BY REGISTRAR <b>APR 11 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

3755

STATE OF TEXAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03749

3754

Item 3 Film G285 4/26/61 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>217 Pennsylvania Ave.</b>		d. STREET ADDRESS <b>1 217 Pennsylvania Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>I.</b> Last <b>Craze</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Midland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Craze</b>		14. MOTHER'S MAIDEN NAME <b>Mary Buskirk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>War I</b>		16. SOCIAL SECURITY NO. <b>705-09-2430</b>	
17. INFORMANT <b>Mrs. Joseph Craze, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>APRIL 17, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 20, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 20 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		BIRTH DATE [REDACTED]		BIRTH PLACE [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		EDUCATION [REDACTED]	
PRESENT ADDRESS [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
DATE OF EXAMINATION [REDACTED]		TIME OF EXAMINATION [REDACTED]		PLACE OF EXAMINATION [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF NEXT OF KIN [REDACTED]		SIGNATURE OF SURVIVOR [REDACTED]	
SIGNATURE OF BURIAL OFFICER [REDACTED]		SIGNATURE OF FUNERAL HOME [REDACTED]		SIGNATURE OF CEMETERY [REDACTED]	
SIGNATURE OF HEALTH DEPARTMENT [REDACTED]		SIGNATURE OF BALTIMORE CITY [REDACTED]		SIGNATURE OF STATE DEPARTMENT [REDACTED]	

10

11

RECEIVED BY THE BALTIMORE CITY HEALTH DEPARTMENT  
 BALTIMORE, MARYLAND  
 [REDACTED]

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3755

03750

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>LESTER</b> Last <b>CREEK</b>				4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1890</b>		9. AGE (In years last birthday) <b>70 30 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Piney Plains, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Creek</b>				14. MOTHER'S MAIDEN NAME <b>Maud Golden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-7764</b>		17. INFORMANT <b>Mrs. C.L. Creek, Bowman's Addn. Cumberland, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DUE TO Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 5 mos 5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ulcer of Pylorus of Stomach</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12:55, April 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>APRIL 6 1961</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. T. JOHNSON, M.D.</b>				22b. DATE SIGNED <b>4-6-61</b>		22c. PHYSICIAN'S NAME (Type) <b>J. T. JOHNSON, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>P.O.S. of A. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Centerville, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

M

I

CERTIFICATE OF DEATH

3752

DECEASED

WEDNESDAY

21 days

IN 2010

1921

10 Yrs

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03751

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Monmouth</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 40, near Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 Min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA SACREDHEART HOSPITAL, CUMB., Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>JAMES</b> Last <b>DEITZ</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1940</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Potomac State Coll.</b>	
11c. BIRTHPLACE (State or foreign country) <b>Long Branch, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harold G. Deitz</b>		14. MOTHER'S MAIDEN NAME <b>Vincena Kehndy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1958 to 1959 142-30-9362</b>	
17. INFORMANT <b>Geo. Deitz, (Brother)</b>		Address <b>Matawan, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE; MACERATION OF BRAIN</b> DUE TO SKULL FRACTURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was passenger in auto which struck rock cliff.</b>	
20c. TIME OF INJURY Month, Day, Year <b>1961</b> Hour <b>3:30</b> P. M. <b>April 29</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 40 9 Miles East, Cumberland, Alleg. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 29 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 3, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Old Tennent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Englishtown, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>			



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JONES		SEX Male		AGE 45	
DATE OF DEATH April 15, 1951		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home	
OCCUPATION Salesman		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
CITY Baltimore		COUNTY Baltimore		STATE Maryland	
ZIP CODE 21201		MEDICAL HISTORY [Text]		SOCIAL HISTORY [Text]	
PHYSICAL HISTORY [Text]		LABORATORY TESTS [Text]		OTHER TESTS [Text]	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
CITY Baltimore		COUNTY Baltimore		STATE Maryland	
ZIP CODE 21201		MEDICAL HISTORY [Text]		SOCIAL HISTORY [Text]	
PHYSICAL HISTORY [Text]		LABORATORY TESTS [Text]		OTHER TESTS [Text]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3757

03752

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>East Main Street</b>		d. STREET ADDRESS <b>East Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>E.</b> Last <b>Dunn</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1902</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Gale Dunn</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic coronary disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>± 5 yrs.</b> <b>± 15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recurrent auricular fibrillation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11/28</b> <b>1960</b> to <b>4/6</b> <b>1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3/4</b> <b>1961</b> , and that death occurred at <b>7<sup>PM</sup></b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Harra</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b>		22d. ADDRESS <b>26 W. Mechanic St. Frostburg Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Moscow, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

12332

CERTIFICATE OF DEATH

12332

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS - BOSTON

1. Name of deceased: George Washington  
2. Date of death: March 1, 1902  
3. Place of death: Longmeadow, Massachusetts  
4. Age at death: 70  
5. Sex: Male  
6. Race: White  
7. Cause of death: Heart failure  
8. Signature of physician: George Washington  
9. Signature of registrar: George Washington  
10. Date of registration: March 1, 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3758

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03753

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>		c. LENGTH OF STAY IN 1b <b>39yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Street</b>		d. STREET ADDRESS <b>Paradise Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN ANDREW EISENTROUT</b>		4. DATE OF DEATH <b>4/1/1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/1883</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bedford County, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Eisen Trout</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Engle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-9392</b>	
17. INFORMANT <b>Edward Eisen Trout, Midland, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca Prostate</b> DUE TO <b>metastasis bladder &amp; intestines</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>177X</b> (b) <b>4 months</b> (c) <b>time</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1960</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>April 19 61</b> and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis</b>		22b. DATE SIGNED <b>4/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>		22d. ADDRESS <b>2 Broadway, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		25a. REC'D BY REGISTRAR <b>LONACONING, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>APR 4 '61</b>		25c. DATE <b>APR 4 '61</b>	

0353

138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3759

03754

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>221 CECELIA STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>MAY</b> Last <b>ELOSSER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1880</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>02</b> Days <b>02</b>		IF UNDER 24 HRS. Hours <b>02</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Louis F. Elosser</b>				14. MOTHER'S MAIDEN NAME <b>Annie Ramey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. CLYDE CAMPBELL</b> Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis generalised</b> DUE TO <b>4 years</b> (c) <b>4 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 years</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>CUMBERLAND</b>				20g. (County) <b>ALLEGANY</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1961</b> to <b>4/15 1961</b> , that (I) (we) last saw the deceased alive on <b>4/15 1961</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William P. James</b>				22b. DATE SIGNED <b>APR 20 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M. D.</b>				22d. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 19, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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STATE OF MICHIGAN  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

3258

(M)

(1)

FILED IN 3258

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 03755

3760

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>439 Grand Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>439 Grand Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Susan</b> Last <b>Funk</b>			4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 7, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cold Stream, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Brelsford</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Richmond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Harvey Funk</b> Address <b>439 Grand Ave. Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of gall bladder with</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastasis to liver</b> DUE TO (c) <b>Approx 1 year</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 13, 1961</b> , to <b>April 15, 1961</b> , that I last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. M. Faw Jr.</b>				ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>April 17, 1961</b>			
PHYSICIAN'S NAME (Type) <b>W. M. Faw Jr. M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park Cumberland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Md.</b>				24a. RECEIVED BY REGISTRAR <b>APR 19 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 750 ml —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
3761														
03756														
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>2 HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (Warwick & Memorial Aves., <b>MEMORIAL HOSPITAL</b> )					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>762 FAYETTE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>SARA' ROBERTA GARLITZ</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 61</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 20, 1960</b>		9. AGE (In years last birthday) <b>8</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						
13. FATHER'S NAME <b>VINCENT LEROY GARLITZ</b>					14. MOTHER'S MAIDEN NAME <b>NANCY HOLLAND</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Infection</b> <b>754.5</b> DUE TO <b>Viral Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart</b> (c) <b>8 mos -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>48 hrs.</b> <b>48 hrs.</b> <b>8 mos -</b>										INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>48 hrs.</b> <b>8 mos -</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4-24-61</b> to <b>4-25-61</b> , that (I) (we) last saw the deceased alive on <b>4-25-61</b> , and that death occurred at <b>4:05 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>H. W. Eliason</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/26/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>DR. H. W. ELIASON</b>					22d. ADDRESS <b>203 GREENE ST. CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

YR A15 (4)  
13M 9/60

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03238

ALLEGANY

MARYLAND

ALLEGANY

(M)

CUMBERLAND  
105 EIGHTH STREET

CUMBERLAND  
MEMORIAL HOSPITAL  
HARRICK & MEMORIAL  
AVES.,  
S. HOURS

61 52 61  
CARLITZ  
AUGUST 20, 1960  
8

SARVA  
FEMALE  
WHITE  
X

U. S. A.  
CUMBERLAND, MARYLAND  
NANCY HOLLAND

NOTE  
VINCENT LEROY CARLITZ

(I)

MEMORIAL HOSPITAL, CUMBERLAND, MD.

NOTE

*Handwritten notes and signatures, including "Vincent Leroy Carlitz" and "Nancy Holland".*

303 GREENE ST. CUMBERLAND, MD.

DR. H. W. ELIASON

Dr. George Cumberland, MD.  
4/2/61  
Misses David and Catherine, 11/1/61

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DR. S. G. WEISMAN

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3762

CERTIFICATE OF DEATH

Item 8 Film G285 4/21/61 iwk

03757

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 HRS. 20 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>505 GREENE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>HELEN G. GATES</b>			4. DATE OF DEATH Month Day Year <b>14 APRIL 19 61</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25, 1881 1880 80</b>	9. AGE (In years last birthday) yrs. Months Days	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>CHARLES P. REDMAN</b>		
14. MOTHER'S MAIDEN NAME <b>SUSAN HAMILTON</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Arteriosclerosis &amp; Hypertension</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Dehydration - Obstructed Colon - Fecal Impaction</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>4/14/61</b> that (I) (we) last saw the deceased alive on <b>4/13/61</b> and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>S. G. Weisman</b>		M.D.		22b. DATE SIGNED <b>4/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. S.G. WEISMAN</b>		22d. ADDRESS <b>59 GREENE STREET, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 17, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town or county) <b>CUMBERLAND, MD.</b>		23e. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

03731

0366

ALLEGANY

HARRIS

ALLEGANY

CUMBERLAND

3 HRS. 20 MIN.

CUMBERLAND

307 GREENE STREET

MEMORIAL HOSPITAL

APRIL 14 1951

WATER

U.S.

WATER

JUNE 27, 1951

X

FEMALE - COLORADO

U.S.A.

WEST VIRGINIA

HOSPITAL

SUSAN HAMILTON

CHARLES F. BROWN

(1)

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

5:10 A.M.

30 GREENE STREET, CUMBERLAND, MD.

DR. S.E. WEISMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3763

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03758

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b>	
c. LENGTH OF STAY IN 1b <b>18 DAYS</b>		d. STREET ADDRESS <b>ROUTE #1,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVENUES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES W. HARE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>30</b> , Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Hot Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tin Plate Mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Magnolia U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>THOMAS HARE</b>		14. MOTHER'S MAIDEN NAME <b>NANCY DYCHE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>16</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Art. Scl. C.V.D. &amp; Decongestants</b> <b>422.1</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH 18 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Allegany Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/12/61</b> , 19 <b>19</b> , to <b>4/30/61</b> , 19 <b>19</b> ; that (I) (we) last saw the deceased alive on <b>4/30/61</b> , 19 <b>19</b> , and that death occurred at <b>2:25 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. R. J. Williams</b> M.D.		22b. DATE <b>4/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

10358

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MINERAL

WEST VIRGINIA

ALLEGANY

RIPOLEY

18 DAYS

CHESLAND

HOSPITAL  
HOSPITAL & WARREN AVENUE

ROUTE 11

10 APRIL 30 61 JAMES W. JAMES

78 10-9-1932 X WHITE MALE

WEST VIRGINIA HOSPITAL, S. A. TWIN PLACE HILL

HANDY DYCK

THOMAS HART

HOSPITAL - CHESLAND, W.

NO

I

125 S. CENTRE ST., CHESLAND, W.

DR. R. J. WILLIAMS

CHESLAND, W.

1001 Rose Hill Cemetery

Burial

James I. Hester, Chesland, W.

May 4 1961

03759

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0318

CERTIFICATE OF DEATH

3784



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death" are faintly visible.]*

*[Faint, mostly illegible text at the bottom of the document, possibly a signature or additional notes.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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03760

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>				d. STREET ADDRESS <b>427 CHESTNUT STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GERTRUDE ANNA HARTUNG</b>				4. DATE OF DEATH Month Day Year <b>APRIL 29 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-91</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN RANK</b>				14. MOTHER'S MAIDEN NAME <b>HENRETTA SCHALLER RANK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>apoplectic stroke</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>arterial hypertension</b> DUE TO (c) <b>2 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4-26 1961</b> to <b>4-29 1961</b> , that (I) (we) last saw the deceased alive on <b>4-28 19 61</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				22b. DATE SIGNED <b>4-30-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Brings</b>	
22d. ADDRESS <b>57 Green Street, Cumberland, Md.</b>							
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)		23b. DATE THEREOF <b>5/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Stein Inc.</b>				25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

03760

CERTIFICATE OF DEATH

03760

(M)

(1)

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BURIAL

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BURIAL

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BURIAL



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3766

03761

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>1 HR. 18 MIN.</b>				d. STREET ADDRESS <b>15 MARY STREET</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>V.</b> Last <b>HELLER</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 3, 1880</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA-ARTEMAS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE SHAFFER</b>				14. MOTHER'S MAIDEN NAME <b>ELSIE TEWELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Arterio Sclerotic heart disease</b> DUE TO <b>12-1-57</b> (b) <b>Adams-Stokes disease of Synchrony</b> DUE TO <b>12-1-57</b> (c) <b>12-1-57</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-57</b> to <b>4-22-61</b> that (I) <del>was</del> last saw the deceased alive on <b>4-21-61</b> 19 <b>61</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. W. F. WILLIAMS</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALLEGANY

MARYLAND

ALLEGANY

CHARTERS

IN 1915 MIN.

CHARTERS

MEMORIAL HOSPITAL

15 HARRY STREET

EVANS

HEUER

APRIL

WHITE

MARCH 3, 1930

BI

WHITE

OWN HOME

PENNSYLVANIA - ARTS

U.S.

GEORGE SHAFER

ELITE TOWEL

HARRIS & HENRIAL AVENUE

MEMORIAL HOSPITAL - CHARTERS, MARYLAND

HOME

NO

1

*James F. Scottell, Cumberland, Md.*  
*Apr. 23, 1961*  
*121 S. Centre Street, Cumberland, Md.*

Burial

Apr. 23, 1961 Zion Memorial Park

Pennsylvania, D.

James F. Scottell, Cumberland, Md.

NO. 1. F. WILLIAMS

121 S. CENTRE STREET, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3767

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03762

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>4 HRS. 50 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b> d. STREET ADDRESS <b>ROUTE #2, BALTIMORE PIKE</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LESLIE Edgar HINKLE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-1888</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS L. HINKLE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA DICKEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-36-9725</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Far advanced cerebral arteriosclerosis</b> DUE TO (c) <b>6 hrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-11-61</b> to <b>4-11-61</b> that (I) <b>(we)</b> last saw the deceased alive on <b>4-11-61</b> and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Williams</b> M.D.		22b. DATE SIGNED <b>4-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

VR A15 (4)  
15M 9/60



3781

ALLEGANY

WARRAND

ALLEGANY

CUMBERLAND

IN 1925 TO 1911

CUMBERLAND

MEMORIAL HOSPITAL

ROUTE 25, BAITING PINE

LESLIE, WILSON

HICKLE

APRIL 11

61

X

WHITE

10-12-1933

75

WILSON

WILSON

U.S.A.

THOMAS L. HICKLE

MARTIN DICKEN

WARRICK & MEMORIAL AVENUE

MEMORIAL HOSPITAL - CUMBERLAND, WARRAND

*General Hospital*  
*for the treatment of*  
*various diseases*

10:15 P.M. 4-11-61

DR. W. F. WILLIAMS

122 S. CENTRE STREET, CUMBERLAND, MD.

WYOMING, WYOMING

WYOMING, WYOMING

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03763

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8 mos., 1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Callie</b> Middle <b>Ada</b> Last <b>Honeycutt</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Mize</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Snyder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James E. Honeycutt</b> Address <b>508 Hill St., Cumb. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 Arteriosclerotic Heart Disease</b> DUE TO <b>592X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>450 General Arteriosclerosis</b> DUE TO <b>542 Chronic Nephritis</b> (c) <b>304 Severe psychosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304 Severe psychosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 28th, 1960</b> , to <b>Apr. 29th, 1961</b> , that I last saw the deceased alive on <b>April 28th, 1961</b> , and that death occurred at <b>12:20</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>4/29/61</b>	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene Street, Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/1/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10/15/1910]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
DATE OF DEATH [Handwritten: 11/1/1955]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]		COUNTY [Handwritten: Baltimore]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF CORONER [Handwritten: W. B. Jones]		SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Blank]	
CERTIFICATE OF DEATH [Handwritten: 11/1/1955]		DATE OF DEATH [Handwritten: 11/1/1955]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
COUNTY [Handwritten: Baltimore]		CITY [Handwritten: Baltimore]		STATE [Handwritten: Md.]		ZIP CODE [Handwritten: 21201]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03764

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage,</b>		c. LENGTH OF STAY IN 1b <b>30 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>Hook</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21st</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9th, 1904</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Calander Room</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K.S.Tire Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Olin Hook</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-05-2244</b>	
17. INFORMANT <b>Mrs. Laverna Hook, Mt. Savage, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion - acute</b> 420.1 DUE TO <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 1/2 yrs.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>X</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>X</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 59</b> to <b>4/21 1961</b> , that (I) (we) last saw the deceased alive on <b>4/21 1961</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rothstein MD</b>		22b. DATE SIGNED <b>4/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein,</b>		22d. ADDRESS <b>48 Broadway, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>M. E. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Durst</b>		25a. REC'D BY REGISTRAR DATE <b>APR 24 '61</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 14 & 16 Film G292 8/9/61 ink											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 HRS.</b>			
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>MARYLAND</b>				f. COUNTY <b>ALLEGANY</b>				g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLDTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>				h. STREET ADDRESS <b>ROUTE 1</b>				i. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JONAH</b>				4. DATE OF DEATH <b>HOSE</b> <b>APRIL 6 1961</b>				5. SEX <b>MALE</b>			
6. COLOR OR RACE <b>WHITE</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>JAN. 28, 1885</b>			
9. AGE (In years last birthday) <b>76 yrs.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Moorfield</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John See</b>				14. MOTHER'S MAIDEN NAME <b>Sally Hose</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-03-3037</b>				17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Myocardial Infarction, massive</b> DUE TO <b>Hypertension and arteriosclerosis (Cardio-vascular disease?)</b> DUE TO <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>4/20/1</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5 am</b> , 19 <b>61</b> , to <b>6 am</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6 am</b> , 19 <b>61</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>W. Alfred Van Ormer</b>				22b. DATE <b>8 am. 61</b>				22c. PHYSICIAN'S NAME (Type) <b>DR. W. ALFRED VAN ORMER</b>			
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-9-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cem.</b>			
23d. LOCATION (City, town or county) <b>Oldtown, Maryland</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				25a. REC'D BY REGISTRAR <b>APR 11 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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OUTCOME

NEUROLOGICAL HOSPITAL  
MEMORIAL & HARBOR AVES

DATE 1

JOHN

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JAN. 25, 1959

TO

Learned father

of son.

MARYLAND MORTUARY U.S.A.

John Lee

of 1111 Rue

NOTE

NEUROLOGICAL HOSPITAL, CAMBERLAND, MD.

*Handwritten notes:*  
Hypertension, Diabetes, Arteriosclerosis  
Myocardial Infarction, Angina  
+ 8/2/59

10 Apr 61

2 Apr 61 3:00 PM

10 Apr 61

*Handwritten:* Dr. Alfred V. ...

8 Apr 61

DE. V. ALFRED VAN COVER

122 S. CENTRE ST., CAMBERLAND, MD.

April 1

4-2-61

Outgoing call

Outgoing call

James J. ...

James J. ...

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03766

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>1 1/2 Hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>Waldorf Route #2 Box 12A</b>	
3. NAME OF DECEASED (Type or print) First <b>Debra</b> Middle <b>Lorene</b> Last <b>Imes</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 27, 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Marvin D. Imes</b>		14. MOTHER'S MAIDEN NAME <b>Carolynn Sue Townsend</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mr &amp; Mrs Kenneth Townsend</b> Address <b>Dayton, Ohio</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Skull</b> DUE TO (b) <b>(Automobile accident)</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5-10 Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5:30</b> P. M. <b>April 21 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 28 Between Ridgeley &amp; Wiley Ford, Mineral, W. Va</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarselic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarselic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 21, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 26, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Piermont Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Piermont Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		24a. REC'D BY REGISTRAR <b>APR 24 '61</b>	
ADDRESS <b>Cumberland Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

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STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_  
 2. SEX: ☐ MALE ☐ FEMALE  
 3. AGE: \_\_\_\_\_  
 4. DATE OF BIRTH: \_\_\_\_\_  
 5. PLACE OF BIRTH: \_\_\_\_\_  
 6. OCCUPATION: \_\_\_\_\_  
 7. CAUSE OF DEATH: \_\_\_\_\_  
 8. MANNER OF DEATH: \_\_\_\_\_  
 9. SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_  
 10. DATE OF EXAMINATION: \_\_\_\_\_

1



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03767

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dilmond</b> Middle <b>M.</b> Last <b>James</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15th</b> Year <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 7th, 1902</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas James</b>				14. MOTHER'S MAIDEN NAME <b>Annie Hartig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-07-0313</b>			
17. INFORMANT <b>Mrs. Anna M. James, 19 Fairview St. Frostburg, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>arterio-sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis</b> DUE TO (c) <b>Emphysema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2-3 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>4-12</b> 19 <b>61</b> , to <b>4-15</b> 19 <b>61</b> , that (I) ( <del>the</del> ) last saw the deceased alive on <b>4-15</b> 19 <b>61</b> , and that death occurred <b>7:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. C. Diehl</b>				22b. DATE SIGNED <b>4/17/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. C. Diehl</b>				22d. ADDRESS <b>39 W. Main St., Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. P. Durrant</b>				25a. REC'D BY REGISTRAR DATE <b>APR 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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03768

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <u>Allegany</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. STREET ADDRESS <u>1215 Primrose Alley</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clearfield</u> Middle <u>Updyke</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/00</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Westernport</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Allen Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mable Jones Mattie Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u> <u>550.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTESTINAL OBSTRUCTION</u> DUE TO (c) <u>GANGRENOUS APPENDIX</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> 19 <u>61</u> , to <u>4-20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> 19 <u>61</u> , and that death occurred at <u>12:15</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard E. Schindler</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. Schindler</u>				22d. ADDRESS <u>69 Greene Street</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u> <u>Frostburg Funeral Service, 236 Baltimore St.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION  
3774  
3774

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03769

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>	
c. LENGTH OF STAY IN Ib <b>36 Yrs</b>		d. STREET ADDRESS <b>1 Mi N. Westernport</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1 Mi N. Westernport</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruth Elsie Keller</b>		4. DATE OF DEATH <b>April 1 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W hite</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 21, 1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Raines</b>		14. MOTHER'S MAIDEN NAME <b>Ida Baldin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Wilson Keller, Sr.-Westernport, Md.</b>	
17. INFORMANT <b>Wilson Keller, Sr.-Westernport, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial infarct</b> (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>6 hrs.</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dribble, Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , to <b>3-31-61</b> , that (I) (we) last saw the deceased alive on <b>3-28-61</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William W. Lesh</b>		22b. DATE SIGNED <b>4-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William W. Lesh</b>		22d. ADDRESS <b>90 Main St. Westernport Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>El. Boal</b>		25a. REC'D BY REGISTRAR DATE <b>APR 4 '61</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

00300

CERTIFICATE OF DEATH

1974



Alimony

Alimony

Marital Deduction

30 yrs

Marital Deduction

1st 1/2 of estate

1st 1/2 of estate

April 1 1961

Wife

State

Wife

54

Nov. 21, 1974

Wife

Female

1st 1/2

Wife's share

One share

Wife's share

1st 1/2 share

Wife's share



Wife's share, 1st 1/2 share, 1st 1/2 share

Wife

Wife's share, 1st 1/2 share, 1st 1/2 share

Wife's share, 1st 1/2 share, 1st 1/2 share

Wife's share, 1st 1/2 share, 1st 1/2 share

Wife's share, 1st 1/2 share, 1st 1/2 share

1st 1/2 share, 1st 1/2 share, 1st 1/2 share

1st 1/2 share, 1st 1/2 share, 1st 1/2 share

Wife

Wife

Wife's share, 1st 1/2 share, 1st 1/2 share

Wife's share, 1st 1/2 share, 1st 1/2 share

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Wife's share, 1st 1/2 share, 1st 1/2 share

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Wife's share, 1st 1/2 share, 1st 1/2 share

Wife's share, 1st 1/2 share, 1st 1/2 share



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03770**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>4 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bowman's Addition</b>				d. STREET ADDRESS <b>Bowman's Addition</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>Cora B. Knipple</b>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <b>Apr. 23 1961</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 20, 1874</b>	
<b>9. AGE</b> (In years last birthday) <b>87 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Uniontown, Pa.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>James Albright</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie Collier</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. Clarence Appold, Cumberland, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b>            DUE TO <b>CARCINOMA OF RIGHT BREAST</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b) (c)</span> </div> <div style="width: 35%;">           INTERVAL BETWEEN ONSET AND DEATH  <b>6 Months</b>  <b>1-2 Years</b> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <span style="float: right;">Month, Day, Year</span> 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>April 23, 1961</b>	
<b>EXAMINER'S NAME (Type)</b> <b>BENEDICT SKITARELIC, M.D.</b>				<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			
<b>22b. DATE THEREOF</b> <b>Apr. 26, 1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Zion Memorial Park</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Cumberland, Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE APR 26 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Knaus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

(M)

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3776  
CERTIFICATE OF DEATH

03771

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Res. of the service, admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>85X-3</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> <b>LEATHERMAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 4, 1905</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self emp</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH LEATHERMAN</b>		14. MOTHER'S MAIDEN NAME <b>MELISSA OATES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Memorial Hospital - Cumberland, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Cardiac Vascular Disease</b> (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1960</b> to <b>April 1961</b> , that (I) (we) last saw the deceased alive on <b>April 1, 1961</b> , and that death occurred at <b>5:28 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. G. O. Himmelwright</b>		22b. DATE SIGNED <b>4/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE HEREOF <b>4/4/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cern.</b>		23d. LOCATION (City, town or county) (State) <b>Romney Wva</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Meryl Combs</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
ADDRESS <b>Romney Wva</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

Y'IPZEL

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"EVAN HARRIS JONES"

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TOP SECRET

1110314 7834

MEMBER OF HOSPITAL

1994

THEIR OWN . . .

130 WILMINGTON AVE., CHAPLHND, MD.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03772

3777

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>Lifetime</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>216 New Hampshire Ave.</b>				d. STREET ADDRESS <b>216 New Hampshire Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Dewey</b> Last <b>Lewis, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9, 1898</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William E. Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Ella Mae Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Edwin Lewis, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>---</b>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cumberland</b>				20g. (County) <b>Allegany</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an <del>XXXXXX</del> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>APRIL 1, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



03338

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 45		DATE OF DEATH 10/15/1911	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Clerk		EDUCATION High School	
PREVIOUS ILLNESS None		HISTORY OF PRESENT ILLNESS Sudden		HISTORY OF PREVIOUS ILLNESS None		HISTORY OF PREVIOUS ILLNESS None	
SIGNATURE OF EXAMINER J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
DATE OF EXAMINATION 10/15/1911		DATE OF DEATH 10/15/1911		DATE OF DEATH 10/15/1911		DATE OF DEATH 10/15/1911	
PLACE OF EXAMINATION Home		PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home	
CITY Baltimore		CITY Baltimore		CITY Baltimore		CITY Baltimore	
COUNTY Baltimore		COUNTY Baltimore		COUNTY Baltimore		COUNTY Baltimore	
STATE Maryland		STATE Maryland		STATE Maryland		STATE Maryland	
SIGNATURE OF EXAMINER J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
DATE OF EXAMINATION 10/15/1911		DATE OF DEATH 10/15/1911		DATE OF DEATH 10/15/1911		DATE OF DEATH 10/15/1911	
PLACE OF EXAMINATION Home		PLACE OF DEATH Home		PLACE OF DEATH Home		PLACE OF DEATH Home	
CITY Baltimore		CITY Baltimore		CITY Baltimore		CITY Baltimore	
COUNTY Baltimore		COUNTY Baltimore		COUNTY Baltimore		COUNTY Baltimore	
STATE Maryland		STATE Maryland		STATE Maryland		STATE Maryland	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3773

Item 0-1111 6207 4/20/61 iwk

03773

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART DECATUR STREET</b>		d. STREET ADDRESS <b>216 N. CENTRE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>L.</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>4</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/7/86 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>3</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>Charles Conley DECEASED</b>		14. MOTHER'S MAIDEN NAME <b>Cassie Mooney DECEASED</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12 - 31 1961</b> , to <b>4 - 13 1961</b> , that (I) (we) last saw the deceased alive on <b>4 - 13 1961</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>P. W. Ballin</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>R. W. BALLIN, M.D.</b>		22d. ADDRESS <b>62 GREENE ST., CUMBERLAND, MD. 4-14-61</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumberland Md.</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hwang</b>			

03773

CERTIFICATE OF DEATH

03773



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
3779											
03774											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY						a. STATE					
ALLEGANY						MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						b. COUNTY					
CUMBERLAND						ALLEGANY					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
50 MIN.						CUMBERLAND,					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
MEMORIAL HOSPITAL						502 MARYLAND AVENUE					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
SARAH S. MARTIN						APRIL 18 61					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8-1-1883		77 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
HOUSEWIFE								RUSH, MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
SAMUEL WILSON				SUSAN M. SMITH				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes give war or dates of service)						MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
527.2 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Palmonary edema (Congestive heart failure)											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11-13-61 to 4-18-61, that (I) (we) last saw the deceased alive on 4-18-61, and that death occurred at 11:50 P.M. 4-18-61 from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
DR. W. F. WILLIAMS											
22d. ADDRESS											
122 S. CENTRE STREET, CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Entombment											
23b. DATE THEREOF											
April 21, 1961											
23c. NAME OF CEMETERY OR CREMATORY											
Rosehill Cemetery											
23d. LOCATION (City, town or county) (State)											
Cumberland Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE											
Ruth E. Silcox											
ADDRESS											
Cumberland Maryland											
25a. REC'D BY REGISTRAR											
DATE APR 24 '61											
25b. REGISTRAR'S SIGNATURE											
Arthur S. Kline											

(M)

(I)

0373

0373

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

MEMORIAL HOSPITAL

505 HAYWARD AVENUE

SABAH

MIRIAM

S.

APRIL

10

81

FEMALE

WHITE

2-1-1933

37

HOUSEWIFE

RUSH, HARRIAND

SAMUEL WILSON

SUSAN M. SMITH

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

*For information of the hospital*  
*Re: Samuel Wilson*

4-18-61

4-18-61

DR. W. F. WILLIAMS

135 S. CENTRE STREET, CUMBERLAND, MD.

LOUIS T. BILBO

CUMBERLAND, MARYLAND

WOODBRIDGE, MARYLAND

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03775

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DOUGLAS</b> Middle <b>HUGH</b> Last <b>MCCOY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 25, 1890</b>	
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Utility work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HUGH MC COY (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>MARY SHANHOLTZ ( DECEASED)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 05 4759</b>	
17. INFORMANT <b>PATIENTS CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-10-1961</b> to <b>11:4</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-10-1961</b> , and that death occurred at <b>11:4</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James T. Johnson, Jr.</b> M.D.		22b. DATE SIGNED <b>30 P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES T. JOHNSON, JR., M.D.</b>		22d. ADDRESS <b>16 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 14, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Winchester, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

03175

CERTIFICATE OF DEATH

03175

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CHIEF CLERK

*Handwritten signature*

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03776

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>ANN</b> Last <b>MC DANIEL</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 8, 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELLSWORTH THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HESS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b>Left Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs.</b> <b>8 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1960</b> to <b>Apr. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr. 3, 1961</b> , and that death occurred at <b>11:00</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, M.D.</b>		22d. ADDRESS <b>236 W. 1st St. Cumberland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EVERETT CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>EVERETT, PA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

103378

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

103378



ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322  
UCBAW

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3782

Reg. Dist. No. 03777

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	c. LENGTH OF STAY IN 1b <b>X</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jackson Street</b>		d. STREET ADDRESS <b>Jackson Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Melvin</b> Middle <b>Merrbaugh</b> Last <b>X</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1912</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Merrbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Matthews</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-5483</b>	
17. INFORMANT <b>Mrs. Melvin Merrbaugh</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (c) <b>Also old myocardial infarction, left</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 Hrs.</b> <b>1-2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.O. McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W.O. McLane, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E ICHHORN</b>		ADDRESS <b>LONACONING? MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03778**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>223 North Lee Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Chloe</u> Middle <u>Lee</u> Last <u>Moats</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>1</u> Year <u>1961</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/19/89</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife,</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Frederick Lee Lease</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Coleman</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No,</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Cumberland, Md.</u> <u>Mrs. Earl Thompson 563 Patterson Ave.,</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>---</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelis</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelis, M.D.</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>April 1, 1961</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>4/4/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Burial Park</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Cumberland, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. Wayne George</u>						<b>ADDRESS</b> <u>Cumberland, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>APR 4 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (4)  
15M 9/59

1  
3784  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03779

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD. W. Va.</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>MINERAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart DECATUR ST. CUMBERLAND, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>ELIZABETH JAY</b>		Middle <b>JANE</b>		Last <b>MORELAND</b>	
4. DATE OF DEATH Month <b>4/</b>		Day <b>1</b>		Year <b>1961</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/20/68</b>		9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months <b>92</b>		IF UNDER 24 HRS. Days <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>THOMAS HENDERSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY HENDERSON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>memoria + generalized arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>senility</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Levels, West Va.</b>		20g. (County) <b>Levels, West Va.</b>		20h. (State) <b>West Va.</b>		21. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>61</b> to <b>4/1</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>61</b> , and that death occurred at <b>4/1</b> 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>B. M. Schindler</b>		22b. DATE <b>4/4/61</b>		22c. PHYSICIAN'S NAME (Type) <b>B. M. SCHINDLER MD.</b>		22d. ADDRESS <b>43 GREENE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Levels Cemetery</b>		23d. LOCATION (City, town, or county) <b>Levels, West Va.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Keith Skiff</b>		24a. ADDRESS <b>Remay W. Va.</b>		25a. REC'D BY REGISTRAR <b>APR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
OFFICE OF THE ASSISTANT SECRETARY  
FOR PUBLIC AFFAIRS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13 & 14 Film G285 4/24/61 iwk

3785

CERTIFICATE OF DEATH

Reg. Dist. No.

03780

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lavale, Md.</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1228 Vocke Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>T.</b> Last <b>MORGAN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-1886</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Timothy C. Cullen</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Donahue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 Day 3</b> <b>several</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , 19 to <b>April 12, 1961</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>61</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>WOMcLane</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>4-14-61</b>	
PHYSICIAN'S NAME (Type) <b>WOMcLane M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reulah H. Montesi</b>		24a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
ADDRESS <b>23 E. Main, Frostburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

03850

EXTRACT OF DEATH

3885

Alimony

Alimony

Alimony

Alimony

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3786

03781

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural near Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. #2 Williams Road, Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. #2 Williams Road</b>				d. STREET ADDRESS <b>/</b>			
3. NAME OF DECEASED (Type or print) <b>EDGAR LACY MYERS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orchard Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruit Orchard</b>		11. BIRTHPLACE (State or foreign country) <b>Staunton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Myers</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Belle Rankin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT Address <b>Mrs. E.L. Myers, Rt #2 Wms. Rd., Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 DUE TO Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease 24 yrs.</b> lying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>27 May 1961</b> to <b>30 Apr 1961</b> , that (I) (we) lost the deceased alive on <b>29 Apr 1961</b> , and that death occurred at <b>10:35 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David T. Rees</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>David T. Rees, M.D.</b>				22d. ADDRESS <b>702 Montgomery Ave., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

03761

CERTIFICATE OF DEATH

3786

(M)

Allegory

100 West Cumberland

St. Louis, Mo.

WHITE

MALE

1891

Age 35

White

Male

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

EXHIBIT

STANDARD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3787

CERTIFICATE OF DEATH

03782

Item 8 Film G285

4/27/61 ink

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miner's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>Box 166 R.D. #3, (Eckhart)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RANCE</b>		4. DATE OF DEATH Month <b>4</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-1903 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Worker</b>		9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Springfield</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>John D. Myers</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Goodwin</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>213-09-6420</b>		17. INFORMANT <b>Mrs. Susie Myers, R.D.#3, Box 166</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebral Hemorrhage</b> 42010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis Hypertensive Heart Disease 10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>XX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>XX</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>X 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>		20f. (City or town) (County) (State) <b>Frostburg, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/15</b> 19 <b>61</b> to <b>4/19</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> 19 <b>61</b> , and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rothstein M.D.</b>		22b. DATE SIGNED <b>4/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>		22d. ADDRESS <b>48 BROADWAY FROSTBURG MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Eckhart Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montesant</b>		25a. REC'D BY REGISTRAR DATE <b>APR 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

VR A15 (4)  
15M 9/60

03732

1878

(M)

Allegany

Allegany

Emmonsburg

Idoga

Emmonsburg

Box 100  
T.D. 25, (Richmond)

Miner's Hospital

Box 100

WYNN

RANGE

3-22-1908

M

John D. Myers

John D. Myers

Emmonsburg

Emmonsburg

(I)

Box 100, T.D. 25, (Richmond)

Box 100

Emmonsburg

Emmonsburg

Emmonsburg

Box 100

Box 100, T.D. 25, (Richmond)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03783

3788

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone R. D. 2</b>		c. LENGTH OF STAY IN 1b <b>12 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone R.D. 2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Goddard</b> Last <b>Perry</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 30, 1884</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Julius Goddard</b>				14. MOTHER'S MAIDEN NAME <b>Cora Chapin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-7394</b>		17. INFORMANT <b>Karl G. Perry</b> Address <b>Flintstone, Maryland R.D.2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>APRIL 1, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 7, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminister Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminister Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b> <b>Cumberland Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Kline</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45 YEARS		SEX MALE		RACE WHITE		DATE OF DEATH JAN 15 1900		PLACE OF DEATH BALTIMORE	
RESIDENCE 1234 E. BALTIMORE ST.		OCCUPATION CLOCK REPAIRER		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		DISEASE OR INJURY CORONARY ARTERY DISEASE		SYMPTOMS PAIN IN CHEST		TREATMENT MEDICAL		HISTORY NONE		FINDINGS HEART ENLARGED	
SIGNATURE OF EXAMINER J. H. HARRIS		DATE JAN 15 1900		PLACE BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		FEE \$1.00	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3789

03784

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg (Rural)</b> c. LENGTH OF STAY IN 1b <b>40 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #1, Box 393 (Eckhart)</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg (Rural)</b> d. STREET ADDRESS <b>R.D. #1, Box 393 (Eckhart)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK POSENEL</b>				4. DATE OF DEATH Month <b>4</b> Day <b>20th</b> Year <b>19 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1885</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>20th</b> Hours <b>19</b> Min. <b>61</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celenese Corp.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-07-5126</b>			
17. INFORMANT <b>Frank J. Posenel, 415 Bigley Avenue,</b>				Address <b>Baltimore 27, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>2 hrs years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1955</b> to <b>April 20, 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>April 20, 1961</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis</b>				22b. DATE SIGNED <b>4/22/61</b>		22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, MD</b>	
22d. ADDRESS <b>2 BROADWAY, FROSTBURG MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Koutsar</b>				25. REC'D BY REGISTRAR <b>App 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



(M)

(1)

Allegany

Proctor (name)

40 yrs.

Two sons

(name)

M.D. 11, Box 363

(Dorchester)

M.D. 11, Box 363

(Dorchester)

PAID

POSTED

Oct. 8, 1938

70

stated opinion

Defense Corp.

and

unknown

unknown

here

George W. ...

George W. ...

1938-39

X

John B. ...

John B. ...

PAID

PAID

John B. ...

00188

00188



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3790

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03785

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>861 Gephart Drive</b>		d. STREET ADDRESS <b>861 Gephart Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>May</b> Last <b>Rainalter</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carnie, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edwin A. Sherwood</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Lee Rennison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Thornton C. Race</b>		Address <b>Abington, Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> 890.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carbon Monoxide poisoning</b> (c) <b>890.0</b> DUE TO stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary sclerosis marked; myocardial hypertrophy.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Furnace Flue Plugged</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:00 P. M. April 28, 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		DATE SIGNED <b>April 29, 1961</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3791  
CERTIFICATE OF DEATH

03786

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>Mineral</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PATTERSON CREEK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>P.O. BOX 16</b>	
3. NAME OF DECEASED (Type or print) First <b>RONALD</b> Middle <b>MEARLE</b> Last <b>RATCLIFF</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25, 1958</b>
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JUSTIN M. RATCLIFF</b>		14. MOTHER'S MAIDEN NAME <b>EVANGELINE TWIGG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis and Infection</b> 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Letter-Siwe's Disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1960</b> to <b>Apr 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr 27, 1961</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert D. Brodell</b> M.D.		22b. DATE SIGNED <b>4-27-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>		22d. ADDRESS <b>129 S. LIBERTY STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/30/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Ashby Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Fort Ashby, W.Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	

03226

8521

(M)

WEST VIRGINIA

WEST VIRGINIA

ALLEGANY

PATTERSON CREEK

56 DAYS

CUMBERLAND

P.O. BOX 12

MEMORIAL HOSPITAL

APRIL 27 1961

RATCLIFFE

MEALE

BOWMAN

JUNE 27, 1958

WHITE

WILL

U.S.A.

CUMBERLAND, MARYLAND

HOME

EVANGELINE TWIGG

JUSTIN M. RATCLIFFE

(I)

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

11:50 P.M.

129 S. LIBERTY STREET, CUMBERLAND, MD.

DR. ROBERT D. PROCELL

JOHN J. HIGER, M.D.

JOHN J. HIGER, M.D.

1958

JOHN J. HIGER, M.D.

JOHN J. HIGER, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3792  
CERTIFICATE OF DEATH  
03787

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>38 GUM RACE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>MAI</b> Last <b>MAY RECKLEY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-89</b> yrs. <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>XXX Greenridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAFAYETTE DAILEY (D)</b>		14. MOTHER'S MAIDEN NAME <b>SARAH STRAWBRIDGE DAILEY (D)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>CHART</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding from duodenal ulcer</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Osteo Arthritis</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1961</b> to <b>April 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1961</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. J. Johnson Jr.</b>		22b. DATE SIGNED <b>4-27-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. J. JOHNSON JR.</b>		22d. ADDRESS <b>16 GREEN STREET CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/30/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		25a. REC'D. BY REGISTRAR <b>MAY 1 1961</b>	
		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Hunt</b>	

08752

RECEIVED IN DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315

CERTIFICATE OF DRAIN

3302

AL-10

NOT PAID

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RECEIVED

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IN THE NAME OF THE

UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03788

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN lb <u>X</u> <u>Midland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICK J. REILLY</u>				4. DATE OF DEATH Month Day Year <u>4/16/1961</u> <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/16/1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Midland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Reilly</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kenny</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes- War # 2</u>				16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT <u>SIMON REILLY, Cumberland, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated Peptic Ulcer</u> DUE TO (c) <u>It</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W O McLane</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W O McLane MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 16, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHORN</u>				ADDRESS <u>LONACONING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	
				24a. REC'D BY REGISTRAR <u>APR 18 '61</u>			

4850

VR A15 (4)  
15M 9/60

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1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>36 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence after admission) e. STATE <b>MARYLAND</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> g. STREET ADDRESS <b>503 FAYETTE STREET</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b> First Middle <b>F</b> Last <b>ROYCE</b>		4. DATE OF DEATH <b>APRIL 29 1961</b> Month <b>APRIL</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 25, 1895</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>W.VA.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>WILLIAM ROYCE</b>		16. MOTHER'S MAIDEN NAME <b>ANNIE WHITACRE</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b>NO</b>		18. SOCIAL SECURITY NO. <b>213 22 3485</b>	
19. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Carcinoma of Right Lung - Terminal</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Probably a year</b>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING TO DEATH</b>		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1961</b> , to <b>April 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 28, 1961</b> , and that death occurred at <b>7:00 AM</b> from the causes and on the date stated above			
30. SIGNATURE <b>Calvin Y. Hadidian</b> M.D.		31. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 32. ADDRESS <b>WASHINGTON &amp; CUMBERLAND ST., CUMBERLAND, MD.</b>	
33. PHYSICIAN'S NAME (Type) <b>CALVIN Y. HADIDIAN</b>		34. DATE <b>5/1/61</b>	
35. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE THEREOF <b>May 1, 1961</b>	
37. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Burial Park</b>		38. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
39. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b> Cumberland, Md.		40. REC'D BY REGISTRAR <b>MAY 3 '61</b>	
41. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>		42. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	

08389

3794



ALLEGANY

WARTLAND

ALLEGANY

WARTLAND

30 DAYS

WARTLAND

100 RAYMOND STREET

APRIL 27 1961

ROYCE

EDWARD

APRIL 27 1961

WHITE

MALE

U.S.A.

W.V.

ANNIE WHITACRE

WILLIAM ROYCE



SPRINT HOSPITAL, GIBBSVILLE, PA.

WASHINGTON, D.C. 20540

WASHINGTON, D.C. 20540

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3795

03790

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>				c. LENGTH OF STAY IN 1b <b>1 HR. 10 MINS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>				d. STREET ADDRESS <b>201 FOREST OAK DRIVE</b>			
3. NAME OF DECEASED (Type or print) <b>BABY BOY SCHWARTZ</b>				4. DATE OF DEATH <b>APRIL 16, 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 16, 1961</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>10</b>			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY COUNTY MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>HAROLD SCHWARTZ</b>				14. MOTHER'S MAIDEN NAME <b>MARY LEWIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Memorial Hospital, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5</b> DUE TO <b>abruptio placentae - 30-32 wks.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>rematurity</b> (c) <b>rematurity</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/16/1961</b> , to <b>4/16/1961</b> that (I) (we) last saw the deceased alive on <b>4/16/1961</b> , and that death occurred at <b>4:50 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Royce Hodges</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. HODGES &amp; MOULD</b>				22d. ADDRESS <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hohn J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony J. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours.

VR A15 (4)  
15M 9/60

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08280

08280

*Handwritten signature*

ALLEGANY  
GATHERING

1 HR. 10 MIN.

ALLEGANY  
CUMBERLAND, MD.

201 FOREST OAK DRIVE

MEMORIAL HOSPITAL CUMBERLAND, MD.

SCHWARTZ

BOY X

BABY

APRIL 16, 1961

MALE WHITE

ALLEGANY COUNTY, MARYLAND

MARY LEWIS

HAROLD SCHWARTZ

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Memorial Hospital, Cumberland, Md.

Photo

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W/161

W/161

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W/161

DR. HENRICKS & WOULD  
V. FORD LADDER

Cumberland, Md.

Cumberland, Md.

Memorial Hospital

W/161

John A. Taylor, Cumberland, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3796

## CERTIFICATE OF DEATH

03791

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>4 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>62 W. College Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WARNER EDWARD SCOGGAN</b>		4. DATE OF DEATH <b>April 28th 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-1875</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>	11. BIRTHPLACE (County & State, or foreign country) <b>St. Mathew, Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Warner Scoggan</b>	
14. MOTHER'S MAIDEN NAME <b>Lucinda Reynolds</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>263-09-8418</b>		17. INFORMANT <b>Mrs. W.E. Scoggan, 62 W. College Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the Esophagus</b> DUE TO <b>150X</b> Conditions, if any, which gave rise to immediate cause (b) <b>6 months?</b> (a), stating the underlying cause last. (c) <b>6 months?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>X</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> <b>1961</b> to <b>4/28</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> <b>1961</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rothstein M.D.</b>		22b. DATE SIGNED <b>4/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN</b>		22d. ADDRESS <b>48 BROADWAY - FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-1-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Reulah H. Montesant</b>		25. REC'D BY REGISTRAR <b>23 E. Main, Frostburg, Md.</b>	
25a. DATE <b>MAY 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3797

03792

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 HOUR</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> <span style="float: right;">b. COUNTY <b>MINERAL</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT ASHBY</b> d. STREET ADDRESS <b>85x-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>EUGENE N. SHIPMAN</b>			<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>5</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>3-21-1911</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>19</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>B and O RR Co.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>ELKINS, WEST VIRGINIA</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>ERNEST SHIPMAN</b>					
<b>14. MOTHER'S MAIDEN NAME</b> <b>GERTRUDE ROWAN</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Chronic Arteriosclerosis (Status Arteriosclerosis)</b> DUE TO (c) <b>Interval BETWEEN ONSET AND DEATH</b> <b>Several Hours</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>12.30</b> p.m. <b>19 61</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>4.51</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>12.30</b> , 19 <b>61</b> , to <b>4.51</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4.51</b> , 19 <b>61</b> , and that death occurred <b>5:02 P.M.</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>DR. W. F. WILLIAMS</b> M.D.				<b>22b. DATE SIGNED</b> <b>4/5/61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. W. F. WILLIAMS</b>				<b>22d. ADDRESS</b> <b>122 SOUTH CENTRE ST., CUMBERLAND, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8 April 61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mineral Baptist</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Mineral Co., W. Va.</b>				<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Allen M. Ratnach</b>			
<b>25a. REC'D BY REGISTRAR</b> DATE <b>APR 11 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

Kayser, W. Va.

Burial 3 April 61 Mineral Baptist

Mineral Co. W. Va.

DR. W. F. WILLIAMS

122 SOUTH CENTRE ST., CUMBERLAND, MD.

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GERTRUDE ROHAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3798

03793

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN Yr <b>50 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hope Road</b>		e. STREET ADDRESS <b>Hope Road</b>	
3. NAME OF DECEASED (Type or print) <b>Annie D. Siegmyer</b>		4. DATE OF DEATH Month <b>4</b> Day <b>12th</b> Year <b>19 61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>67 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Barton, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Lashbaugh</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Raley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Alberta Siegmyer, Hope Road,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic C-U disease</b> DUE TO (c) <b>± 20 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Post-cholecystectomy syndrome.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>9/21</b> <b>1957</b> to <b>9/12</b> <b>1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3/15</b> <b>1961</b> , and that death occurred at <b>10:15</b> <b>P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Harrat</b>		22b. DATE SIGNED <b>4/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b>		22d. ADDRESS <b>26 W. Mechanic St., Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burial H. Monte...</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03794

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <del>XXXXXXXX</del> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART Hospital</b>		d. STREET ADDRESS <b>1 Douglas Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VERNA</b> Middle <b>SMITH</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>APR</b> Day <b>18</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-5-16</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Creighton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>CHART</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status asthmaticus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Bronchial Asthma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-5-1956</b> to <b>4-18-1961</b> that (I) (we) last saw the deceased alive on <b>4-18-1961</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph L. Ballin</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ralph Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene St. Cumberland, Md. 4-18-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/21/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		25a. REC'D BY REGISTRAR <b>DATE APR 24 '61</b>	
ADDRESS <b>LONA CONING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

3800

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03795

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>31 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>207 GREEN STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>STEVENSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-24-98</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDING FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ALLEGANY BALLISTICS LAB. MARYLAND Midland U.S.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM J. STEVENSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. CRAZE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-5711</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic Carcinoma, with primary site in right lung, metastases to left lung and pleura with</b> (c) <b>some to liver; right pleural effusion.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>10 months (?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension; Malnutrition due carcinomatosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>September, 1960</b> to <b>April 6th, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 5th, 1961</b> , and that death occurred at <b>3 a M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wyand F. Doerner</b>		22b. DATE SIGNED <b>4-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wyand Doerner, MD</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR DATE <b>Apr 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>			

0328

CERTIFICATE OF DEATH

3200

(M)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3801											
CERTIFICATE OF DEATH											
03796											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>9 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES., MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>111 LAING AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E DGAR</b> Last <b>STEVENSON</b>						4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1893</b> <b>AUGUST 24, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Box Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, Midland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE H. STEVENSON</b>						14. MOTHER'S MAIDEN NAME <b>SARAH E. WINTERS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>502.0</b> DUE TO (b) <b>Pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Pulmonary Emphysema &amp; Fibrosis &amp; Chronic Bronchitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 days</b> <b>Years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Adynamic Ileus due to generalized Toxicity; Possible terminal CVA</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 12th, 1961</b> to <b>April 13th, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 12th, 1961</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Wyand F. Doerner, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 14, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>WYAND F. DOERNER, Jr., M.D.</b>						22d. ADDRESS <b>CUMBERLAND, MARYLAND WASHINGTON &amp; CUMBERLAND ST.,</b>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafez, Jr.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

(M)

(1)

1030

1030

ALLEGANY

WYOMING

ALLEGANY

CUMBERLAND

2 DAYS

CUMBERLAND

111 LIND AVENUE

MEMORIAL HOSPITAL  
WASHINGTON, D.C.

STEVENSON

2 YEARS

WASH

AUGUST 21, 1940

WASH

U.S.A.

WYOMING, WYOMING

General Post Co.

1. Power

SARAH E. WINTERS

GEORGE H. STEVENSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

to

3 days

Conjunctive Heart Failure

10 days

Pericarditis

Pulmonary Embolism & Infarction; Chronic Bronchitis

Adverse Effects due to generalized Toxicity; Possible terminal DVA

April 14th of April 1940

April 12th, 1940

April 11, 1940

x

CUMBERLAND, WYOMING

WASHINGTON, D.C.

WYOMING, D.C.

*Handwritten signature*

*Handwritten notes and signatures at the bottom of the page.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
3802  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03797

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>9 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL DECATUR ST.</b>				d. STREET ADDRESS <b>619 1/2 N. CENTRE ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GUS</b> Middle <b>W.</b> Last <b>WIGFIELD</b>				4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/85</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.		IF UNDER 24 HRS. Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP OF AMERICA</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>JONATHAN (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>SHRYOCK (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-10-4475</b>		17. INFORMANT <b>CHART</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma - prostate</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>4/10</b> 19 <b>61</b> to <b>4/10</b> 19 <b>61</b> , that (I) (the hospital) last saw the deceased alive on <b>4/10</b> 19 <b>61</b> , and that death occurred at <b>5:55</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter N. Himmler</b>				22b. DATE SIGNED <b>4/10/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER N. HIMMLER M.D.</b>				22d. ADDRESS <b>412 N. MECHANIC ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. REC'D BY REGISTRAR <b>APR 17 '61</b>	

00701

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERANS AFFAIRS  
OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C. 20460

100

11



1



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. \*Deputy Medical Examiner, Dr. B. Skitarelic, was notified 5:20 p.m. 4-14-61, and he gave me permission to sign death certificate. 17-1

1  
3803  
M  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03798

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robin Street</u>		d. STREET ADDRESS <u>Robin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1898</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Galenease Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Boyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-07-2903</u>	
17. INFORMANT Address <u>Mrs. Robert Williams Lonaconing, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-1-0X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>chronic myocarditis</u> DUE TO lying cause lost. (c) <u>mitral insufficiency-aortic stenosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"Wife"</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1958</u> to <u>March 3, 1961</u> that (I) (we) last saw the deceased alive <u>March 3, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Overton Himmelwright</u> M.D.		22b. DATE SIGNED <u>4-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>		22d. ADDRESS <u>133 Virginia Ave.-Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Moscow, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u> ADDRESS <u>Lonaconing, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

83738

83803

(10)

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the memorandum body is illegible due to extreme fading and bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3804  
CERTIFICATE OF DEATH  
03799

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>34 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miner's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>170 W. Mechanic Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William J. Willison</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6 1905</b> 9. AGE (In years last birthday) <b>55 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Works</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas Willison</b>	
14. MOTHER'S MAIDEN NAME <b>Lillie Twigg</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Wm. J. Willison, 170 W. Mechanic St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>593X uremia</b> DUE TO <b>nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1961</b> to <b>April 22, 1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 22, 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>4/24/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, MD</b>		22d. ADDRESS <b>2 Broadway, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-24-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	23d. LOCATION (City, town or county) _____ (State) _____ <b>Eckhart Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montague</b>		25a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

003700

3804

(M)

Allegory

Prosthetic

Allegory's Hospital

William

J. William

June 8 1905

W. W.

Prosthetic

Own Business

Business, W.

Thomas William

Little T. W.

W. W.

W. W. J. William, W. W. Thomas, W.

*Prosthetic*

*5 days*

*X*

W. W. J. William, W. W. Thomas, W.

*W. W. J. William, W. W. Thomas, W.*

*70 W. W. J. William, W. W. Thomas, W.*

*W. W. J. William, W. W. Thomas, W.*



03800

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural National Highway LaVale, Md.</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Regina</b>		Middle <b>E.</b>		Last <b>Wilson</b>		4. DATE OF DEATH Month <b>April</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b>		IF UNDER 24 HRS. Days <b>2</b>		Hours <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Corriganville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Augustus Burkey</b>				14. MOTHER'S MAIDEN NAME <b>Rose Mattingly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastritis - Diabetes Mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>61</b> , to <b>4/2</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/2</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo H. Ley, Jr.</b>		M.D. <b>LEO H. LEY M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/4/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>456 N. Center St. Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 5, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc. Cumberland, Md</b>				25a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

03800



CERTIFICATE OF DEATH

1907

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3806											
03801											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. LENGTH OF STAY IN b <b>6 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PERCIVAL Raymond WRIGHT</b>						4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 9, 1880</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>				11. BIRTHPLACE (County & State, or foreign country) <b>CRESAPTOWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ELBERT WRIGHT</b>						14. MOTHER'S MAIDEN NAME <b>MARY MYERS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis and Congestive heart Failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 9, 1961</b> to <b>April 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1961</b> , and that death occurred at <b>2:20 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Walter N. Mimmeler</b>						22b. DATE SIGNED <b>4/17/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. WALTER MIMMLER</b>						22d. ADDRESS <b>412 N. MECHANIC ST. CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Hofer</b>						25a. REC'D BY REGISTRAR DATE <b>APR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>			

(M)

(I)

ALLGARY

CUMBERLAND

MEMORIAL HOSPITAL

PERCTVAL

8 days

WRIGHT

APRIL 15

MALE

WHITE

X

DECEMBER 9, 1880

Self employed

Carriage

CLERT WRIGHT

MARY WRIGHT

GRESHAM, MARYLAND

U. S. A.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

10

DR. WALTER MINNELL

112 N. MECHANIC ST. CUMBERLAND, MD.

*James H. Hays, M.D.,  
112 N. Mechanic St.,  
Cumberland, Md.*

3806

103801

ALLGARY

MARYLAND

CUMBERLAND

6 DAYS

WRIGHT & MEMORIAL  
HOSPITAL

1113 BRADDOCK ROAD

APRIL 15



03803

03803

ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

CUMBERLAND

BEDFORD ROAD

AVENUE

MEMORIAL HOSPITAL

11 11 61

APRIL

YERGAN

E.

SADIE

MARCH 13-1870

X

FEMALE WHITE

PERCILLA HARDEN

JOHN S. HIDDLETON

MEMORIAL HOSPITAL, CUMBERLAND

*Central University  
The reference is to the  
University of*

4-11-61  
5:30 PM

*Mr. Williams*

122 SOUTH O CENTRE ST. CUMBERLAND, MD.

W. F. WILLIAMS

March 11, 1961  
Cumberland  
Maryland